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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 06/13/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:
Orthopaedic Surgery

Description of the service or services in dispute:

L4-S1 mini 360 with decompression with 2 day LOS

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who reported an injury on XX/XX/XX. The mechanism of injury was lifting. His diagnosis was noted as postlaminectomy syndrome, lumbar region. The patient's surgical history was noted to include discectomy performed in XX/XX, discectomy and laminectomy performed in XX/XX, and discectomy and laminectomy performed in XX/XX.

During the assessment on XX/XX, the patient complained of continued low back pain. The patient reported pain at night that awoke him from sleep, and indicated that rising from a chair, physical activity, and cold weather made the pain worse. The records indicate that the patient is a current every day smoker, smoking 1 pack per day. During the physical examination, the patient stood with an erect posture, demonstrating a normal gait pattern. There was significant spinal tenderness in the paraspinal muscles. The bilateral straight leg raise was negative. There was normal sensation to light touch and normal motor strength in both lower extremities. Reflexes in the lower extremities were normal at 2/4. The patient demonstrated poor range of motion with flexion, extension, side bending, and rotation. There was pain with spinal motion. X-rays performed in office revealed no instability. There was a normal appearance to the disc, with severe collapse degeneration of the L4-5 disc. An MRI of the lumbar spine performed on XX/XXXX was noted to reveal a 3.3 mm bulge at L4-5, flattening the thecal sac without causing central stenosis; no protrusion seen at L4-5; bulge, disc narrowing, and facet joint hypertrophy causing moderate bilateral foraminal stenosis at L4-5. There was also a 4.3 mm bulge at L5-S1, abutting the thecal sac without causing central stenosis or displacement of the S1 nerve roots. The bulge, disc narrowing, and facet hypertrophy caused mild bilateral foraminal stenosis at L5-S1.

The patient underwent a presurgical psychological evaluation on XX/XXXX. During the evaluation, the patient indicated that he needed to know more before proceeding with the surgery, especially potential functional limitations and recovery, as well as alternatives. The evaluating physician indicated that the patient should return to discuss the surgery with XX. It was noted that the patient requested another opinion, and had previously discussed the fusion with XX, who had advised against it, causing confusion in the patient. It was noted that based on the presurgical psychological screening, the patient was cleared for

surgery with a fair to good psychosocial prognosis for pain reduction and functional improvement. It was noted that the patient had significant anxiety, and anxiolytic medication was recommended, as well as 2 sessions of individual psychotherapy.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The decision to deny the requested L4-S1 mini 360 with decompression with 2 day length of stay should be upheld.

Per the peer reviewed literature referenced, for those patients who do not improve with conservative care, surgery is considered an appropriate treatment alternative. The primary objective of surgery is to reconstitute the spinal canal. The role of fusion in the absence of degenerative deformity is uncertain. Lower level evidence exists, however, that does not demonstrate an added benefit of fusion for those patients; therefore, in the absence of deformity of instability, the inclusion of a fusion is not recommended. Discectomy improves low back pain in patients suffering from lumbar disc herniation. Patients with/without modic type 1 change showed a similar improvement in low back pain score. Per the Milliman Care Guidelines, lumbar fusion is indicated for spinal stenosis requiring stabilization; lumbar spondylolisthesis; or lumbar pseudoarthrosis.

The patient reported pain at night that awoke him from sleep, and indicated that rising from a chair, physical activity, and cold weather made the pain worse. The patient demonstrated poor range of motion with flexion, extension, side bending, and rotation. The bilateral straight leg raise was negative. The x-rays performed in office revealed no instability. The MRI of the lumbar spine performed on XX/XXXX revealed bulge, disc narrowing, and facet hypertrophy causing mild bilateral foraminal stenosis at L5-S1. There was a normal appearance to the disc, with severe collapse degeneration of the L4-5 disc. Additionally, records indicate that the patient is a current every day smoker, smoking 1 pack per day. There was no indication that the patient was advised to refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

Moreover, there was no indication the patient received the second opinion requested; as it was noted that XX advised against the surgery; and the patient had significant anxiety.

Therefore, the requested L4-S1 mini 360 with decompression is not supported for this patient. The 2 day length of stay is also not supported, as the requested surgical procedure was found not medically necessary.

Based on the above, the decision to deny the requested L4-S1 mini 360 with decompression and 2 day length of stay should be upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)